ID #:_____

Workshop # _____

Healthier Living Workshop

Evaluation

Baseline

☐ CDSMP ☐ Diabetes ☐ Chronic Pain

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Revised 04-26-2011

Name: _____ Today's date: _____

Address: _____

City, state, zip: _____

Telephone: home (____) _____ - _____ work (____) _____ - _____

Cell ( ) _____ - _____

Email address: _____

Date of birth: month: _____ day: _____ year: _____ Sex: □ Female □ Male

Background

1. Ethnic origin (check □ **only one**):

□ White not Hispanic
□ Asian or Pacific Islander
□ Black not Hispanic
□ Filipino
□ Hispanic
□ American Indian/Alaskan Native
□ Other: _____

2. Please circle the **highest** year of school completed:

1 2 3 4 5 6 (Primary) 7 8 9 10 11 12 (high school/GED) 13 14 15 16 (college/university) 17 18 19 20 21 22 (graduate school) 23+

3. Are you currently (check □ **only one**):

□ Married
□ Separated
□ Widowed
□ Single
□ Divorced
□ Civil union
□ Other: _____

4. Please indicate below which chronic condition(s) you have:

□ Diabetes
□ Asthma
□ Emphysema or COPD
□ High Blood Pressure/Hypertension
□ Back or neck pain
□ Fibromyalgia
□ Depression or Anxiety
□ Other mental health issues: type of mental health issue _____
□ Other lung disease: type of lung disease: _____
□ Heart disease: type of heart disease: _____
□ Arthritis or other rheumatic disease: specify type: _____
□ Cancer: type of cancer: _____
□ Other chronic condition: specify condition: _____

General Health

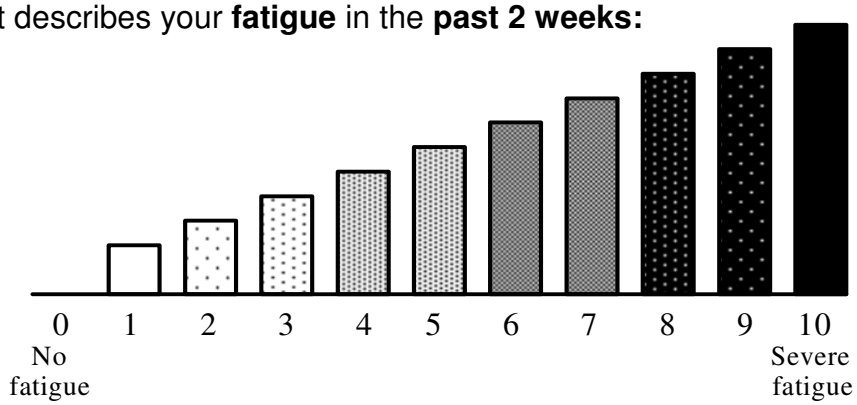
	Excellent	Very Good	Good	Fair	Poor
1. In general, would you say your health is (circle one)	1	2	3	4	5

Symptoms

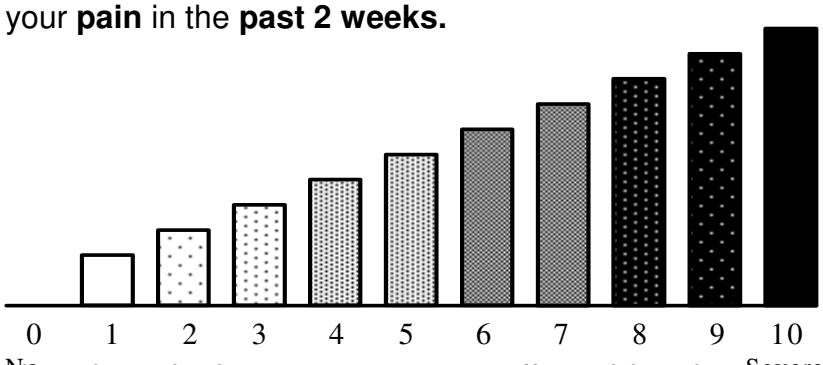
How much time during the **past month** (Please circle one number for each question):

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
1. Were you discouraged by your health problems?	0	1	2	3	4	5
2. Were you fearful about your future health?	0	1	2	3	4	5
3. Was your health a worry in your life?	0	1	2	3	4	5
4. Were you frustrated by your health problems?	0	1	2	3	4	5

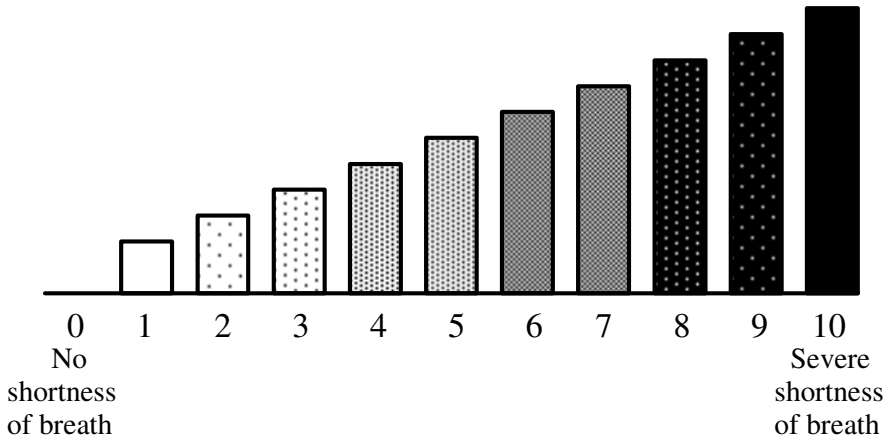
5. We are interested in learning whether or not you are affected by fatigue. Please circle the number below that describes your **fatigue** in the **past 2 weeks:**



6. We are interested in learning whether or not you are affected by pain. Please circle the number below that describes your **pain** in the **past 2 weeks.**



7. We are interested in learning whether or not you are affected by shortness of breath. Please circle the number below that describes your **shortness of breath** in the **past 2 weeks:**



Physical Activities

During the past week, even if it was not a typical week for you, how much **total** time (for the **entire week**) did you spend on each of the following (please circle one number for each question):

	none	less than 30 min/wk	30-60 min/wk	1-3 hrs per week	more than 3 hrs/wk
1. Stretching or strengthening exercises (range of motion, using weights, etc.)	0	1	2	3	4
2. Walk for exercise	0	1	2	3	4
3. Swimming or aquatic exercise	0	1	2	3	4
4. Bicycling (including stationary exercise bikes)	0	1	2	3	4
5. Other aerobic exercise equipment (Stairmaster, rowing, skiing machine, etc.)	0	1	2	3	4
6. Other aerobic exercise specify_____	0	1	2	3	4

Coping With Symptoms

When you are feeling down in the dumps, feeling pain or having other unpleasant symptoms, how often do you (please circle one number for each question):
:

	Never	Almost never	Some-times	Fairly often	Very often	Always
1. Try to feel distant from the discomfort and pretend that it is not part of your body.....	0	1	2	3	4	5
2. Don't think of it as discomfort but as some other sensation, like a warm, numb feeling....	0	1	2	3	4	5
3. Play mental games or sing songs to keep your mind off the discomfort.....	0	1	2	3	4	5
4. Practice progressive muscle relaxation.....	0	1	2	3	4	5
5. Practice visualization or guided imagery, such as picturing yourself somewhere else...	0	1	2	3	4	5
6. Talk to yourself in positive ways	0	1	2	3	4	5

Physical Abilities

At this moment, are you able to (please circle one number for each question):
:

	Without any difficulty	With some difficulty	With much difficulty	Unable to do
1. Dress yourself, including tying shoelaces and doing buttons?.....	0	1	2	3
2. Get in and out of bed?.....	0	1	2	3
3. Lift a full cup or glass to your mouth?.....	0	1	2	3
4. Walk outdoor on flat ground?.....	0	1	2	3
5. Wash and dry your entire body?.....	0	1	2	3
6. Bend down to pick up clothing from the floor?.....	0	1	2	3
7. Turn faucets on and off?.....	0	1	2	3
8. Get in and out of a car?.....	0	1	2	3

Daily Activities

During the **past 4 weeks**, how much (please circle one number for each question):

	Not at all	Slightly	Moderately	Quite a bit	Almost totally
1. Has your health interfered with your normal social activities with family, friends, neighbors or groups?	0	1	2	3	4
2. Has your health interfered with your hobbies or recreational activities?	0	1	2	3	4
3. Has your health interfered with your household chores?	0	1	2	3	4
4. Has your health interfered with your errands and shopping?	0	1	2	3	4

Medical Care

When you **visit your doctor**, how often do you do the following (please circle one number for each question):

	Never	Almost never	Some-times	Fairly often	Very often	Always
1. Prepare a list of questions for your doctor	0	1	2	3	4	5
2. Ask questions about the things you want to know and things you don't understand about your treatment	0	1	2	3	4	5
3. Discuss any personal problems that may be related to your illness	0	1	2	3	4	5

4. **In the past 6 months**, how many times did you visit a physician? Do **not** include visits while in the hospital or the hospital emergency department. _____ visits

5. **In the past 6 months**, how many times did you go to a **hospital** emergency department? ..... _____ times

6. **In the past 6 months**, how many times were you hospitalized for one night or longer? ..... _____ times

   a. How many total NIGHTS did you spend in the hospital **in the past 6 months**? ..... _____ nights

   b. Were any of these hospitalizations at a skilled nursing facility, convalescent hospital, or other minimum care facility? (circle one) ..... Yes No

Confidence About Doing Things

For each of the following questions, please circle the number that corresponds with your confidence that you can do the tasks regularly at the present time.

How confident are you that you can:

1. Keep the fatigue caused by your disease from interfering with the things you want to do?

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

2. Keep the physical discomfort or pain of your disease from interfering with the things you want to do?

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

3. Keep the emotional distress caused by your disease from interfering with the things you want to do?

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

4. Keep any other symptoms or health problems you have from interfering with the things you want to do?

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

5. Do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

6. Do things other than just taking medication to reduce how much your illness affects your everyday life?

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

Patient Activation Measure

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think the doctor wants you to say.

If the statement does not apply to you, circle N/A.

When all is said and done, I am the person who is responsible for managing my health condition	Disagree Strongly 1	Disagree 2	Agree 3	Agree Strongly 4	N/A 5
Taking an active role in my own health care is the most important factor in determining my health and ability to function	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I know what each of my prescribed medications does	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident I can tell a doctor concerns I have even when he or she does not ask	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident that I can follow through on medical treatments I need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I understand the nature and causes of my health condition(s)	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I know the different medical treatment options available for my health condition	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I have been able to maintain the lifestyle changes for my health condition that I have made	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I know how to prevent further problems with my health condition	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident I can figure out solutions when new situations or problems arise with my health condition	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
I am confident that I can maintain lifestyle changes, like diet and exercise, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

Thank you for your help!

This questionnaire was developed by:
Stanford Patient Education Research Center